MISSISSIPPI BOARD OF PHARMACY

6360 I55 North, Suite 400
JACKSON, MS 39211
sparker@mbp.ms.gov

Office: 601-899-8880
Fax: 601-899-8904
www.mbp.ms.gov

PHARMACY BENEFIT MANAGER APPLICATION

Application for License, Renewal, Amendment & Reporting Instructions. (Changes require a new application. Integral changes will require an additional licensing fee of $500.00)

Pursuant to Miss. Code Ann. § 73-21 -157 (1); "Before beginning to do business as a pharmacy benefit manager, a pharmacy benefit manager shall obtain a license to do business from the board. To obtain a license, the applicant shall submit an application to the board on a form to be prescribed by the board."

License Period:

January 1st

through

December 31st

Annually

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PHARMACY BENEFIT MANAGER (PBM)
~ Instructions and Frequently Asked Questions ~

PLEASE READ CAREFULLY

The following 'Application for License for Pharmacy Benefit Manager (PBM)' should be used for ALL PBMs including Initial PBM Applications, Renewal Applications and Integral Changes to a PBM with an existing license.

⇒ *BE PROMPT AND ON TIME*

A complete Application for Pharmacy Benefit Manager License, as prescribed by the MISSISSIPPI BOARD OF PHARMACY, must be received by the Board **postmarked no later than December 31st annually**. Licenses are issued for the calendar year or January 1st through December 31st. 'Pro Rata' licenses are not allowed by the Board.

ALL APPLICATIONS NOT POSTMARKED OR DIGITALLY (EMAILED) RECEIVED ON OR BEFORE DECEMBER 31ST WILL BE HELD AS 'PENDING', A LATE FEE OF $500.00 WILL BE ASSESSED AND NOT PROCESSED UNTIL THE LATE FEE IS RECEIVED; THE ISSUE MAY BE FORMALLY BROUGHT BEFORE THE BOARD FOR CONSIDERATION OF AN ADDITIONAL MONETARY PENALTY AND/OR OTHER ACTION.

* ***Pursuant to Miss. Code Ann. § 73-21-103 (d) (vii); "a monetary penalty of not more than $1000.00 per day may be imposed upon any person or business that practices or does business without a license."***

⇒ *DO NOT FORGET TO INCLUDE PAYMENT.*

A NON-REFUNDABLE license fee of **$500.00** must be received by the Board before the application will be considered complete. ***[Make check or money order payable to the MISSISSIPPI BOARD OF PHARMACY].***

⇒ *"WE ARE NOT A PHARMACY BENEFIT MANAGER (PBM)"*

On July 1, 2014 a new definition of Pharmacy Benefit Manager became effective.
This is now a part of Mississippi Code of 1972 Annotated § 73-21-179 Definitions, (d). [see below]

> *(d) "Pharmacy benefit manager" means a business that administers the prescription drug/device portion of pharmacy benefit management plans or health insurance plans on behalf of plan sponsors, insurance companies, unions and health maintenance organizations. Pharmacy benefit managers may also provide some, all, but may not be limited to, the following services either directly or through outsourcing or contracts with other entities:*
>
> *(i) Adjudicate drug claims or any portion of the transaction.*
> *(ii) Contract with retail and mail pharmacy networks.*
> *(iii) Establish payment levels for pharmacies.*
> *(iv) Develop formulary or drug list of covered therapies.*
> *(v) Provide benefit design consultation.*
> *(vi) Manage cost and utilization trends.*
> *(vii) Contract for manufacturer rebates.*
> *(viii) Provide fee-based clinical services to improve member care.*

⇒ *'Doing Business As' DBA:*

The Applicant / PBM name must be the name by which the PBM operates at the transaction level. A PBM cannot operate under a license of a parent company in another name. Each DBA must have a separate license.

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Continued...

We hear from some PBMs that *"we do not do business in Mississippi"* or *"we are not a PBM".*

Whether you are acting as a Pharmacy Benefit Manager will be determined by the definition above.

The determination of whether you do business in Mississippi is based upon the transaction. If the transaction occurs in Mississippi, the patient is in Mississippi or the prescription is shipped into Mississippi, etc. - you are then doing business in Mississippi.

⇒ *CONTACT INFORMATION*

Contact phone numbers and email addresses MUST provide direct access to a decision making authority. Call centers or Service Centers WILL NOT be accepted as the PBM contact. The numbers provided will be tested.

⇒ *SECTION 5, QUESTION 1:*

A certified record of "**Certificate of Good Standing**" and, if applicable, a "**Certificate of Existence**" from the Office of the Mississippi Secretary of State. (REQUIRED EVEN IF DOMICILED IN ANOTHER STATE.) **Mississippi Board of Pharmacy regulation ARTICLE XLV, 2., A., a., ii.**

⇒ *REPORTING OF AUDITED FINANCIAL STATEMENTS:*

- **THE REPORTING PERIOD MUST BE FOR THE PREVIOUS FISCAL YEAR.**
- **'AUDITED FINANCIAL STATEMENT' MEANS** the Financial statements and related disclosures in accordance with United States Generally Accepted Accounting Principles (GAAP) of the specific entity / licensee operating in Mississippi. This should be prepared by a Certified Public Accountant.
- Previous fiscal year Audited Financial Statement report must accompany application for a NEW PBM LICENSE.

IF YOUR AUDITED FINANCIAL STATEMENT IS NOT AVAILABLE BY THE MARCH 1ST REPORTING DEADLINE, YOU MAY PROVIDE A PRELIMINARY INTERNAL FINANCIAL STATEMENT ALONG WITH YOUR FINANCIAL REPORT BY MARCH 1ST WITH A PROJECTED DATE THAT WE MAY EXPECT TO RECEIVE FROM YOU THE FINAL AUDITED STATEMENT. THIS PRELIMINARY REPORT MUST BE IN OUR OFFICE NO LATER THAN THE MARCH 1ST REPORTING DEADLINE AS REQUIRED BY THE STATUTE PRINTED BELOW. THE FINAL AUDITED FINANCIAL STATEMENT MUST BE RECEIVED IN OUR OFFICE NO LATER THAN JUNE 30TH.

(See PBM Financial Statement Reporting Form)

ALL DOCUMENTS SHOULD BE SENT ELECTRONICALLY TO:
sparker@mbp.ms.gov
Cc: pculbertson@mbp.ms.gov

ALL CHECKS MUST BE MAILED TO THE ADDRESS BELOW.
The application will be held pending until check is received.
BE CERTAIN TO ENTER CHECK NUMBER ON THE APPLICTION!
Attention: PBM Administrator
MISSISSIPPI BOARD OF PHARMACY
6360 I55 North, Suite 400
Jackson, Mississippi 39211

Steve Parker
PBM Administrator
Mississippi Board of Pharmacy

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PHARMACY BENEFIT MANAGER (PBM)
APPLICATION FOR LICENSE

Any answers, explanations or omissions found to be false or deceptive may result in the Board denying issuance of, or revocation of your license in the State of Mississippi.

☐ **Initial Application (NEW)**

☐ **Renewal Application / Permit #_____**

ENTER CHECK NUMBER TO BE MAILED:_____

☐ **Amendment**

☐ **Integral Change** *(At Minimum, anything that changes the face of the permit will be considered an Integral Change. The MSBOP will make the final determination of an integral change.)*

INITIAL, RENEWAL OR INTEGRAL CHANGES MUST INCLUDE A $500.00 FEE.

Section 1: General Information

Applicant / Corporate Name: *(This will be the name of the licensed entity.)*

_____

Federal Tax ID#:

_____

Applicant / Corporate Physical Address:

_____

_____

_____

*Zip Code*_____ *County / Parish* _____

Applicant / Corporate Mailing Address: *(If Different) [Your permit will be mailed to this address. If it should be directed to a specific office or person please specify.]*

_____

_____

_____

_____

State in which PBM is domiciled:

_____

Website / URL of Applicant:

_____

Date your fiscal year ends?

____/____/_____

Section 2: Contact Information

Administrative Officer with Responsibility for MISSISSIPPI OPERATIONS

This individual will be the primary contact for the applicant. The intent of this question is for you to provide a contact with "decision making authority" for use by the Mississippi Board of Pharmacy in contacting the company. This should NOT be a phone bank, call center or a customer service number, but a specific person in authority.

Name:

Title / Position:

Address:

_____

_____

_____

Direct Phone #:

_____ - _____ - _____

Direct Cell #:

_____ - _____ - _____

Email:

_____

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Section 3: Background / Historical Information

Not Applicable or N/A is not an accepted response.

Question 1: Has the Applicant been refused a registration, license or certification to act as (or provide the services of) a Pharmacy Benefit Manager, Pharmacy Benefit Management Plan, Pharmacy Benefits Processor, Third Party Administrator, Third Party Provider, etc., or has any registration, license or certification to act as such been denied, suspended, revoked or non-renewed for any reason by any state or federal entity? *(Attach specific details separately.)*	☐ YES ☐ NO
Question 2: Has the Applicant ever been found liable in any lawsuit or arbitration proceeding involving allegations of fraud, illegal or dishonest activities in connection with the administration of pharmacy benefit management services? *(Attach specific details separately.)*	☐ YES ☐ NO
Question 3: Has the Applicant had a business relationship with an insurance company, provider or payor terminated for any alleged fraudulent, illegal or dishonest activities in connection with the administration of pharmacy benefit management services? *(Attach specific details separately.)*	☐ YES ☐ NO
Question 4: Has the applicant, parent company or any company or organization controlling the operation of the applicant experienced any data security breaches or HIPAA security breaches? *(If YES please attached all pertinent information concerning any data security breach. (Any future data security breach must be reported immediately to the Mississippi Board of Pharmacy.)*	☐ YES ☐ NO
Question 5: Does the applicant hold any other licenses, registrations or permits in Mississippi? *(Attach specific details separately.)*	☐ YES ☐ NO
Question 6: Is the applicant currently involved in any dispute or controversy with any regulatory authority? *Attach details.*	☐ YES ☐ NO
Question 7: Has the business entity or any owner, partner, officer or director of the business entity or member or manager of a limited liability company, ever been convicted of a military offense, had a judgment withheld or deferred, or is the business entity or any owner, partner, officer or director of the business entity or member or manager of a limited liability company, currently charged with committing a military offense? *If so attach details.*	☐ YES ☐ NO
Question 8: Is the applicant currently a defendant or the subject in any legal action alleging fraud, dishonesty or breach of trust on the part of the applicant or its officers, directors, trustees or members? *(If yes, supply a statement giving the jurisdiction of the case, a summary of the allegations, the case style (name) and a summary of the current status of the case.)*	☐ YES ☐ NO
Question 9: Is the applicant currently undergoing an examination or audit (whether routine, targeted or otherwise) being conducted by any state or federal regulatory authority? *Attach details.*	☐ YES ☐ NO
Question 10: Is the applicant or its parent corporation a publicly traded company? *(If yes, attach a copy of the most recent 10K or equivalent filing.)*	☐ YES ☐ NO

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Section 4: Applicant Operational Information

Not Applicable or N/A will not be accepted as a response.

Question 1: Does the Applicant conduct audits of pharmacies and pharmacists in accordance with the provisions of Miss. Code Ann. § 73-21- 175 through 73-21-191 also known as the 'PHARMACY AUDIT INTEGRITY ACT'? *(If audit services are not provided by PBM internally, provide entity name(s) and contact information of contracted entity that provides this service to PBM.)*	☐ YES ☐ NO
Question 2: Does the applicant contract with an entity for audit services? **If Yes provide a copy of the contract with those entities.**	☐ YES ☐ NO
Question 3: Does the Applicant have an internal grievance process for patients or pharmacies? *If so list the contact information and procedure.*	☐ YES ☐ NO
Question 4: Does Applicant comply with Miss. Code Ann. § 73-21-151 through § 73-21-159 known as the 'PHARMACY BENEFIT PROMPT PAY ACT', including, but not limited to, item § 73-21-155 item (2) - reading: *"Pharmacy benefit managers, their agents and other parties responsible for reimbursement for prescription drugs and other products and supplies shall be required to update the nationally recognized reference prices or amounts used for calculation of reimbursement for prescription drugs and other products and supplies no less than every three (3) business days."* *Three (3) business days are required by statute and cannot be changed by the Board of Pharmacy.*	☐ YES ☐ NO
Question 5: In accordance with Miss. Code Ann. § 73-21-106, does the Applicant own, operate or affiliate with any pharmacy located outside the State of Mississippi that ships, mails or delivers in any manner, controlled substances, prescription or legend drugs or devices into this State? i.e., mail order service? *If yes…provide list & contact information.*	☐ YES ☐ NO
Question 6: Within the last five years, has the applicant merged or consolidated with any other entity? (*If yes, attach details.)*	☐ YES ☐ NO
Question 7: Does the applicant pay any representative given discretion as to the settlement, adjustment of claims or audit of claims, whether in direct negotiations with the claimant or in supervision of the person negotiating, a compensation which is in any way contingent upon the amount of the settlement of such claims? (*Attach details.)*	☐ YES ☐ NO
Question 8: Within the last five years, has the applicant undergone a change in ownership (direct or indirect) of 10 percent or more? *(If yes, provide a full explanation of the change in ownership and an organizational/ownership chart which clearly shows the ownership of the licensee both before and after the transaction.)*	☐ YES ☐ NO

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Section 5: Required Additional Information *To Be Attached*

ATTACH DETAILS / EXPLANATIONS AS AN ADDENDUM TO THIS APPLICATION.

1. A certified record of "**Certificate of Good Standing**" and, if applicable, a "**Certificate of Existence**" from the Office of the Mississippi Secretary of State. (REQUIRED EVEN IF DOMICILED IN ANOTHER STATE.) *All certified documents required in the application must be dated within ninety (90) days of submittal of the application.*	☐ ATTACHED
2. In the case of a Pharmacy Benefit Manager being domiciled outside of the State of Mississippi; a certificate of good standing from the appropriate official State entity where the Pharmacy Benefit Manager, company or organization is domiciled.	☐ ATTACHED
3. A report containing the details of any suspension, sanction, penalty, regulatory, consent agreement or other similar action relating to the Pharmacy Benefit Manager, controlling company or organization, in the State of Mississippi or any other State, territory or country.	☐ ATTACHED
4. The name, address and contact information of the Agent of Record or services of process for the Pharmacy Benefit Manager in Mississippi, along with contact information.	☐ ATTACHED
5. A list of the PBMs management and owners. Give the full legal name , resident address, position with the applicant and the percentage of ownership (if applicable) of all natural persons responsible for the conduct of affairs of the applicant. *This list should include all officers, all directors, all partners (in the case of a partnership), all trustees, all executive committee members and every natural person owning, directly or indirectly, 10 percent or more of the applicant and any other natural person who exercises control or influence over the affairs of the applicant).*	☐ ATTACHED
6. A complete list of all BIN#'s (Bank Identification Number), IIN#'s (Issuer Identification Number), PCN#'s and Payer Details currently associated with your company as of the date of this application. **YOUR RESPONSE MUST BE REPORTED USING THE EXCELL SPREADSHEET TEMPLATE PROVIDED TO: sparker@mbp.ms.gov.** ***SEND AS AN ACTUAL EXCELL ATTACHEMENT AND NOT A SCANNED OR PDF COPY.***	☐ **CLICK HERE** FOR LINKED SPREADSHEET
7. A description of the geographical services area of the Pharmacy Benefit Manager.	☐ ATTACHED
8. A list of all entities on whose behalf the Pharmacy Benefit Manager has contracts or agreements to provide pharmacy benefit services.	☐ ATTACHED
9. The number of total enrollees or lives served under all of the Pharmacy Benefit Manager's contracts or agreements in Mississippi (separately) and nationwide (inclusively).	☐ ATTACHED
10. Your contingency plan describing how contracted Pharmacy Benefit services will be provided in the event of insolvency of the applicant.	☐ ATTACHED
11. The most recently concluded fiscal year-end financial statement(s) for the applicant and its controlling company or organization, which statements have been audited by an independent certified public accountant (CPA) under U.S. generally accepted accounting principles (GAAP).	☐ ATTACHED
12. The name(s) and contact information of the public accounting firm and internal accountant(s) preparing or assisting in the preparation of financial statements.	☐ ATTACHED
13. Attach a complete chart / list of the ownership structure of the applicant.	☐ ATTACHED
14. Attach a copy of the PBM's standard, generic contract template which it uses for contracts entered into by the PBM and Pharmacies or Pharmacy services administrative organizations in this State in administration of pharmacy benefits for Healthcare insurers, providers or payors.	☐ ATTACHED
15. **INITIAL LICENSING APPLICATION ONLY**: The applicant must submit the following required documentation: All basic organization documents of the administrator, including the Articles of Incorporation, Articles of Association, Partnership agreements, trade name certificate, trust agreements, shareholder agreement and all amendments to such documents.	☐ ATTACHED

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Section 6: Applicant Responsible Party Attestation

ATTESTATION

By signing this attestation, I understand that I will be considered the Permit Holder of Record for the Pharmacy Benefit Manager (PBM).

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION MAY BE PROSECUTED UNDER APPLICABLE STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OR REVOCATION OF LICENSE.

The information required herein is continuing in nature and, as the individual responsible for preparing this document, I agree to furnish an update on any information in this application.

As an authorized representative of the Applicant, I hereby certify under penalty of perjury, that:

All of the information submitted in this application and attachments is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application may be grounds for revocation or denial of licensure and may subject me to civil or criminal penalties. Applicant understands and will comply with the laws and regulations of the State of Mississippi to which application for licensure is hereby made:

_____
SIGNATURE

_____ _____
PRINTED NAME of Chief Executive Officer (CEO) **DIRECT ACCESS PHONE NUMBER**

_____
ADDRESS 1

_____
ADDRESS 2

_____ _____
CITY, STATE, ZIP **DATE SIGNED**

This form must be signed by the Chief Executive Officer (CEO).